GAYLORD HOSPITAL, INC. & AFFILIATES
Gaylord Farm Road, Wallingford, CT 06492
(203) 284-2885
Authorization for Release/Receipt of Protected Health Information

Patient: _____ **Date of Birth:** _____ **Medical Record#:**_____

Address: _____**Telephone #:** _____

All information below must be completed to release information in accordance with this request.

1. I authorize Gaylord Hospital to: _____ release information from the health record of the above named patient to:
   _____ receive information from the health record of the above named patient from:

Name/Organization:_____ **Telephone:** _____

Street Address/PO Box:_____

City/Town: _____ **State:** _____ **Zip Code:** _____

2. The purpose for such information is: [ ] Legal [ ] Disability [ ] Workers' Comp [ ] Personal [ ] Insurance
   [ ] Continuum of Care [ ] Other (Specify):_____

3. Requested Information

_____All Records
_____Medical abstract (inpatient summary)
_____Assessments
_____Outpatient Clinic
_____Sleep Services
_____Therapy (PT, ST, OT, etc.)
_____Financial/Billing
_____Other (specify):_____

Specific Report(s) – check all that apply:

- ❑ History/Physical
- ❑ Consultation
- ❑ Discharge Summary and Diagnosis
- ❑ EKG and/or EMG
- ❑ Laboratory
- ❑ Radiology: ____Report ____ Films
- ❑ Other:_____

4. Approximate date(s): _____, (information collected before/after the dates specified will not be released).

5. This form serves the dual purpose of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations. Documentation to be released may contain psychiatric, psychological, HIV/AIDS, alcohol, drug information. I authorize release of this information _____ (specify the information to be released, if applicable)_____(initial here if applicable).

6. I understand there may be a 65-cent/per-page copy and applicable mailing fees charged with certain requests for my health information. I have 30 days to receive a copy of my records unless otherwise specified.

7. I understand I may revoke this authorization at any time, and must do so in writing to Gaylord Hospital's Privacy Officer. I understand the revocation will not apply to information that has already been released in response to this authorization. This authorization is valid for one (1) year unless it is revoked.

8. I understand authorizing the disclosure of this health information is voluntary. I need not sign this authorization to ensure treatment, payment or healthcare operations

9. I understand my information once released from this facility may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized redisclosure.

_____ _____

Signature of Patient/Legal Representative **Date**

To verify identity, a notarized signature *may* be required for records to be released to you or your representative.

If Legal Representative, specify relationship (must provide a copy of supporting documentation: conservator, etc.):

- ❑ The patient is a minor, _____ years of age
- ❑ The patient is unable to authorize because: _____

Form #: 9213.201a